Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of	**)**	
	)	
Rural Health Care Support Mechanism	**)**	WC Docket No. 02-60

COMMENTS OF THE HEALTH INFORMATION EXCHANGE OF MONTANA

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SUMMARY

HIEM is a not-for-profit collaboration of healthcare providers in communities across northwest and north central Montana, established to develop and share electronic health information and to improve patient care throughout a shared service area. HIEM is also a successful Rural Health Care Pilot Program participant that deployed new broadband infrastructure across the incredibly rugged and remote region served by its healthcare provider members. HIEM thus has first-hand experience with the Commission's efforts to improve the Rural Health Care program through the Pilot Program.

HIEM welcomes both the Wireline Competition Bureau's public notice seeking comment on the proposed broadband services program, and the Commission's commitment to complete the Rural Health Care program reform effort it began in 2010. Notwithstanding the Bureau's focus on broadband services rather than broadband infrastructure, HIEM's experience as a network construction project in the Pilot Program shows the utility of funding health infrastructure in situations where the competitive bidding process establishes that it is more cost effective than leasing equivalent facilities or services. However, HIEM proposes some modifications to the competitive bidding process that will provide assurance that construction of new facilities occurs only when and where it is needed.

HIEM is on schedule to complete in late fall 2012 the initially funded parts of its Pilot Program network. HIEM is ready to complete the remainder of the proposed network which will add the network redundancy that is critical to HIEM's members. Accordingly, HIEM urges the Commission to maintain the successful policies concerning health infrastructure that conserved limited RHC funding and were proven successful in the Pilot Program.

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The Health Information Exchange of Montana ("HIEM"), by its attorneys, hereby submits these comments in response to the Public Notice released by the Wireline Competition Bureau ("WCB" or "Bureau") in July 2012, in the above captioned proceeding.[1] The *RHC PN* seeks to establish a "more focused and comprehensive record" in this proceeding in certain specific areas in order to help the Federal Communications Commission ("FCC" or "Commission") "craft an efficient and permanent [Rural Health Care] program" to further broadband use by health care providers. HIEM applauds this effort and offers comments below in several specific areas. As requested by the Bureau, HIEM ties its responses back to specific sections of the *RHC PN*.

I. BACKGROUND

HIEM is a not-for-profit collaboration of healthcare providers in communities across northwest and north central Montana, established to develop and share electronic health information and to improve patient care throughout a shared service area. The HIEM shared service area spans both sides of the Continental Divide and features difficult terrain, harsh and unpredictable weather, and sparse population. HIEM is the recipient of a $13.6 million Rural

[1] *Wireline Competition Bureau Seeks Further Comment on Issues in the Rural Health Care Reform Proceeding*, WC Docket 02-60, Public Notice, DA 12-1166 (rel. Jul. 19, 2012) (*RHC PN*).

Health Care ("RHC") Pilot Program ("Pilot" or "Pilot Program") funding award and one of the successful infrastructure projects in that program.[2] The Commission's Pilot Program grant to HIEM represented 50% of what the HIEM requested to build out its network. Subsequently, HIEM requested additional Pilot Program funding in an effort to complete the network as originally proposed.[3]

Through the competitive bidding process, HIEM discovered that the most cost-effective means of implementing its network was to build middle- and last-mile fiber to its health care members' facilities. By investing in its own network, HIEM is not dependent on recurring monthly support from the RHC program, and expects its network to be self-sustaining throughout the life of the fiber it has installed. Moreover, by avoiding uncompetitive offers to lease network facilities from commercial providers, HIEM's network saved the RHC pilot program a substantial amount of money to-date; by making a significant one-time investment, HIEM's network has successfully reduced demands for RHC funding over the longer term.

If the Commission does not grant HIEM's existing request for additional program funds to complete its network, HIEM urges the Commission to adopt permanent RHC program rules that will allow HIEM to seek additional one-time funding that will support HIEM's continuing efforts to bring affordable and redundant broadband access to health care providers in northwest

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[2] For additional background, see HIEM's previous comments in this and related proceedings: HIEM RHC NPRM Comments, WC Docket 02-60 (filed Sep. 8, 2010) (*NPRM Comments*); HIEM RHC NPRM Reply Comments, WC Docket 02-60 (filed Sep. 23, 2010) (*NPRM Reply Comments*); HIEM RHC Supplemental Funding Reply Comments, WC Docket 02-60 (filed Mar. 7, 2011) (*Supplemental Funding Comments*); Brazos Valley Council of Governments, HIEM, et al. CAF NPRM Comments, WC Docket No. 10-90, et al. (filed May 23, 2011) (*CAF NPRM Comments*); HIEM Notice of Oral *Ex Parte* Presentation, WC Docket 02-60 (filed Sep. 22, 2011) (*September 2011 Ex Parte*); HIEM RHC NPRM Further Comments, WC Docket 02-60 (filed May 25, 2012) (*Further Comments*).

[3] *See* Public Notice, *Wireline Competition Bureau Seeks Comment on Health Information Exchange of Montana Request For Additional Funding Under The Rural Health Care Pilot Program*, WC Docket No. 02-60, DA 11-95 (rel. Jan. 19, 2011); *see also HIEM Supplemental Funding Comments.*

Montana. In particular, the Commission must maintain its long-standing commitment to *competitive bidding* as the best and proven method for ensuring cost-effective deployment of advanced services for health care providers.[4] HIEM's experience in the Pilot Program conclusively shows that limiting or reducing competitive options will result in increased costs to health care providers and the waste of limited universal service funding.

II. ELIGIBLE SERVICES AND EQUIPMENT

A. Pilot Program Data on Funding Commitments Does Not Accurately Reflect the Demand for Infrastructure Funding (*Response to Section III Paragraph 9 of the* RHC PN)

The Bureau explains that "although the Pilot Program permitted projects to construct and own broadband network facilities, many projects elected to lease broadband services (which mostly involve recurring costs) rather than constructing and owning the broadband facilities themselves."[5] The Bureau then cites USAC data that breaks down Pilot Program funding commitments into three categories: construction, leased/tariffed facilities or services, and network equipment. The Bureau notes the largest amount of Pilot funding was committed to "leased/tariffed facilities or services" and from that, appears to suggest that this is evidence of a lack of need for new infrastructure deployment.[6] However, as the Commission considers how much RHC funding to devote to broadband services vs. broadband infrastructure, it should not misconstrue this data.

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[4] *See* 47 U.S.C. § 254(h)(2) (requiring the Commission to "establish competitively neutral rules . . . to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and nonprofit . . . health care providers . . . .").

[5] *RHC PN* at ¶ 9.

[6] *See id.* (noting that as of January 31, 2012, $162 million was committed for leased/tariffed facilities or services, $35 million for construction, and $19 million for network equipment). Subsequent to the *RHC PN,* USAC released more detailed data indicating, among other things, that as of January 31, 2012, over $43 million of the $162 million cited by the Bureau was committed to fund fiber IRUs or pre-paid leases. *See* Letter from Craig Davis, Vice President, Rural Health Care Division, USAC, to Julie Veach, Chief, WCB, FCC, Appendix I (Aug. 9, 2012).

Two factors must be considered when considering the data on Pilot Program funding commitments: First, it has been widely recognized and acknowledged by the Commission that a lack of funding for administrative costs depressed the ability of projects to take advantage of infrastructure support. Second, the USAC category of "leased/tariffed facilities or services" includes both facilities and services and thus includes an infrastructure component (even if the projects did not need or choose to construct that infrastructure). Each of these factors is discussed further below.

One of the shortcomings of the Pilot Program was the lack of funding available for administrative expenses. As the Commission previously observed:

> Our experience with the Pilot Program supports the need to provide some amount of funding for administrative expenses in infrastructure projects, to support the process of designing the network and securing necessary agreements. Participants have indicated that the costs associated with infrastructure deployment can be a considerable financial burden on participants. . . .[7]

This lack of administrative support was clearly a factor for projects deciding instead to lease services from existing providers rather than deploy their own facilities.[8] HIEM was fortunate that its members recognized the long-term benefits of the HIEM network and so committed funds for the substantial start-up costs needed to implement this network. However, the fact that other projects initially expected that Pilot Program funding would help them with these costs

[7] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Notice of Proposed Rulemaking, 25 FCC Rcd 9371, 9386, ¶ 37 (2010) (*RHC NPRM*); *see also* U.S. Government Accountability Office Report: FCC's Performance Management Weaknesses Could Jeopardize Proposed Reforms of the Rural Health Care Program, GAO-11-27, at 35, 37 (Nov. 2010) (*GAO Report*) (noting that one of the significant difficulties Pilot participants faced was funding ineligible expenses including "administrative costs").

[8] The Bureau notes as much but appears to ignore the fact that this skews the commitment data rather than reinforces it. *See RHC PN* at ¶ 9 (noting projects choosing to lease services cited administrative costs associated with network ownership as one of the factors). Moreover, it was not just lack of support for administrative costs that depressed infrastructure deployment; it was also delay caused by uncertainty over how projects were required to handle excess capacity and "fair share". *See GAO Report* at 43 (noting early and continuing questions concerning excess capacity and fair share).

cannot be ignored. As a result, the Commission cannot simply conclude that the disparity between Pilot Program spending on "construction" vs. "leased/tariffed facilities or services" was due principally to a preference from health care providers to have carriers manage everything for them.

Secondly, the USAC data cited in the *RHC PN* fails to break down commitments for "leased/tariffed facilities or services" between facilities and services.[9] This is a critical distinction that has important policy implications. Leasing services may reflect a situation where the service provider is providing a total solution to the health care providers with full responsibility for network management and operations, subcontracting last-mile connectivity, and for providing network equipment including maintenance and upgrades. In such cases, these costs are built into the cost of the service and recovered through the rates charged.

In contrast, where health care providers enter into a long term agreement for a facility, such as dark fiber, they may contract with multiple service providers to provide the various other functions necessary to implement their network.[10] There may also be hybrid situations where health care providers lease broadband connectivity as a service from one provider, buy equipment from another, and either manage the network itself or procure a third service provider vendor to do so.[11] USAC's category of "leased/tariffed facilities or services" includes commitments to projects in all of these situations and thus obscures the distinction between

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[9] As noted above, USAC subsequently provided detail concerning the subset of commitments within this category focused on IRUs and pre-paid leases. *See* fn. 6, *supra*.

[10] *See, e.g.*, Illinois Rural HealthNet, Pilot Program Quarterly Report, WC Docket 02-60, at 10-12, response to #3 Network Narrative (filed Jul. 10, 2012) (noting use of multiple vendors to provide a combination of leased and owned fiber, wireless connectivity, and network operations center services).

[11] *See, e.g., id.* (also obtaining connectivity as a service); New England Telehealth Consortium, Pilot Program Quarterly Report, WC Docket 02-60, at 81-82, response to #3 Network Narrative (filed Jul. 31, 2012) (noting use of multiple vendors to provide a combination of leased services for connectivity with a project-controlled network operations center).

expenditures for health care providers managing and controlling their own networks and for those paying a single service provider to do everything for them.

Both service provider controlled networks and health care provider controlled networks offer different benefits and challenges. But which approach is taken should be determined by health care providers after an open and thorough competitive bidding process, and after an assessment of long-term cost effectiveness. With a match-funding requirement, health care providers' interests will naturally align with the Commission in assuring the most cost-effective deployment of USF funds.[12]

The point is this: the Commission cannot conclude from the data provided by USAC that the network-as-service approach is optimal. Accordingly, the new rules for RHC broadband must support multiple approaches by permitting health care providers to procure their network in the most cost-effective fashion, without being forced to contract with a single provider, and/or being forced to obtain networks only as a service.

B. **Where Construction of Network Facilities is More Cost Effective, it Should Be Permitted** (*Response to Section III Paragraph 10.c of the* RHC PN)

HIEM reiterates its strong support for a dedicated health infrastructure funding mechanism as was originally proposed by the Commission. As HIEM has observed previously, one-time investments in facilities can reduce the demand for perpetual subsidies.[13] The Bureau

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[12] *See National Broadband Plan* at 215 ("The [15%] match requirement [used in the Pilot Program] aligns incentives and helps ensure that the health care provider values the broadband services being developed and makes financially prudent decisions regarding the project."); *cf. Federal-State Joint Board on Universal Service*, Report and Order, 12 FCC Rcd 8776, ¶ 727 (1997) (*Universal Service Order*) (rejecting additional requirements on HCPs because of adequate program incentives to "not waste their own resources by paying" for services they do not need); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546, 24575-6, ¶ 58 (2003) (HCP responsibility for "significant portion of service costs" ensures health care providers will select most cost-effective services).

[13] *See e.g., HIEM Further Comments* at 6-9 (citing *The Omaha Plan* which discusses how the Schools and Libraries program's over-reliance on recurring subsidies has resulted in an "entitlement

in a recent staff report acknowledges, based on the experience of some Pilot projects including HIEM, that construction of new infrastructure can be a lower cost option than leasing.[14] However, the Bureau in the *RHC PN* appears to step back from a full commitment to the efficient use of RHC support, seeking comment on whether infrastructure funding should be available within the broadband services program "to recipients to construct their own network facilities under limited circumstances."[15] The Bureau asks specifically whether last-mile construction of facilities owned by health care providers should ever be funded, and asks what requirements should be in place to ensure that construction is the more cost effective option. The Bureau also asks whether caps should be placed on this type of limited infrastructure support.

1. Infrastructure Investment Should Not Be Limited to the Last Mile

HIEM supports the continued use of competitive bidding for all RHC applicants so that support is used efficiently. The current rules require RHC participants to select the vendor offering the most cost-effective option to provide the facilities or services. In HIEM's experience, this rule is critical to the program's success. Accordingly, if the Commission decides not to proceed with a dedicated health infrastructure program and instead opts to make infrastructure support available through the broadband services program, the Commission should not limit such support to last-mile connectivity. HIEM's experience here is instructive.

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program that will last forever"). HIEM has repeatedly addressed this issue and hereby incorporates its prior comments. *See* fn.2, *supra*;

[14] *See* Wireline Competition Bureau, Evaluation of Rural Health Care Pilot Program, Staff Report, WC Docket 02-60, DA 12-1332, ¶ 48 (rel. Aug. 13, 2012) (*Pilot Program Staff Report*) (citing Pilot Program examples); *see also id.* at ¶ 49 (recognizing that the "self-construction option . . . provides Pilot project health care providers with higher-bandwidth services at only an incrementally higher cost to the fund . . . than the current [RHC] Primary Program"). Note however, that "higher bandwidth" in Pilot Program construction projects means many-to-many fiber connections from 10 Mbs to as high as 1 Gig, as compared to the point-to-point circuits in the 1.5 to 3 Mbs range" in the Primary Program. *See id.; HIEM Further Comments* at 6-7 (noting availability of 1 Gig connections on the HIEM network and using Pilot Program example to compare the long-term costs of leasing vs. constructing).

[15] *See RHC PN* at ¶ 10.c. (emphasis added), n.40.

In developing its Pilot Program network, HIEM sought through the competitive bidding process middle- and last-mile fiber connectivity in order to bring affordable broadband service to remote locations. HIEM was agnostic on whether to build or obtain IRUs or long-term leases to secure this connectivity. Much to HIEM's surprise, commercial service providers were unwilling or unable to offer leased facilities at a price which, over the life of the proposed network, did not exceed the cost for HIEM to hire a vendor to construct its own fiber links. Some bidders quoted such extraordinary prices for leased facilities that HIEM would have been limited to connecting only a few facilities and would have exhausted all of its allocated program funds within just a few years.[16] Given that HIEM had to raise a 15% match, this was a completely unacceptable option.

That a vendor capable of constructing facilities could quote a price lower than a commercial service provider with facilities already in the ground surprised HIEM. HIEM also encountered one carrier that expressed an intention to use program funds to overbuild its own fiber links, despite the fact that it had ample dark fiber available to provide service. These experiences should give the Commission every reason to preserve the infrastructure program going forward and ensure that no support is permitted to flow to carriers unless it is vetted through the competitive bidding process. The Commission must be careful about funding a carrier with facilities in the ground, subsidized by federal and state universal service support, and subsidized loans from the Rural Utilities Service, that is unwilling to put forward a bid that is competitive with the retail cost of building new facilities.

[16] HIEM suspects the pricing reflected a belief that HIEM would never complete its network. The fact that HIEM has proven that it can and will build facilities if it is compelled to will likely result in more competitive pricing if similar situations are encountered in the future.

Ideally new construction should *rarely* be necessary. However, it is the *option* to construct, even if rarely or never exercised, that constrains pricing offered by existing providers – particularly in areas that have little or no competition. Simply ensuring the option exists will conserve and stretch USF dollars; otherwise, the Commission risks perpetuating a system that has been effectively cutting blank checks to local service providers for many years.[17]

Accordingly, the Commission should provide RHC funding for the construction of any broadband infrastructure – last-mile or middle-mile – in much the same way it was permitted under the Pilot program: through the competitive bidding process. Under what conditions construction should be allowed and how to ensure its cost effectiveness is discussed below.

2. Whether to Construct or Lease Facilities Should be Determined after the Competitive Bidding Process

The Bureau asks "[w]hat requirements . . . need to be in place to ensure that construction and ownership [of network facilities] is the most cost-effective option? . . . Would it be necessary to wait until after the competitive bidding process is completed in order for an applicant to be able to make that showing?" In HIEM's experience, the decision to construct was made after an evaluation of bids made in response to its RFP. HIEM's RFPs did not contain a presumption that bidders would be constructing facilities. HIEM sought the most cost effective means of obtaining the needed connectivity, and the bids received dictated that construction was the preferred course. HIEM could have implemented its existing network with dark fiber IRUs if those had been made available at a competitive price.[18] Similarly, in order to complete the

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[17] *Cf. RHC PN* at ¶ 11.b, n.52 (between 2006 and 2010, outside of Alaska, only 11% of applicants in the legacy RHC program received competitive bids in response to requests for services).

[18] *Accord* Comments of the Iowa Rural Health Telecommunications Program, WC Docket 02-60, at 2 (filed Aug. 20, 2012) ("Vendor bids from the competitive bidding process during the Pilot program clearly demonstrated whether an IRU or actual construction/ownership was the most cost effective approach.").

designed but un-implemented sections of HIEM's network, dark fiber IRUs remain an option – but only if they are priced in such a way that it would not be less costly to build the facilities! The only way to provide that assurance is to use the competitive bidding process to ensure that all parties put their best bid on the table.

The Commission could reasonably prohibit requests for proposals in the proposed RHC broadband services program from presuming construction as a preferred means of delivering the requested service or facility. That way, a provider with existing facilities would always have an opportunity to make dark fiber IRUs or equivalent leased facilities available at a competitive price. HIEM would support such a limitation.

3. Funding for Constructing Facilities Should Not Be Capped and Should be Permitted Whenever it is More Cost Effective Than Leasing an Equivalent Facility Over a Period of Time Reflecting the Expected Life of the Asset

The Commission notes that the definitions of "cost-effective" are different in the Schools and Libraries program and the RHC program, with the RHC's definition providing greater latitude to health care providers to consider factors other than price.[19] To allay concerns regarding overbuilding, the Commission could consider requiring price to be the primary factor when the question is whether to build or lease an otherwise comparable facility.[20] This would make sense only in situations where facilities can be easily compared using purely objective metrics – for example, strands of dark fiber. In contrast, when seeking a service from a vendor

[19] *See RHC PN* at n.43.

[20] HIEM recognizes that price comparisons must consider cost of ownership over the life of the asset and must be "apples-to-apples." For example, in comparing the price for a fiber lease that includes maintenance to the price to build facilities capable of carrying the same capacity, health care providers would have to gross-up the build price to reflect the expected cost for maintenance over the expected life of the asset. Although health care providers should continue to be allowed to install excess capacity on an incremental cost basis (without RHC funds), the potential proceeds from leasing such excess capacity should be excluded from the cost-of-ownership calculations.

in the health care setting, the Commission correctly recognizes that factors such as quality and reliability may be more important than price.[21]

While this may be a reasonable step to take, HIEM cautions the Commission not to erect unnecessary process barriers to implementing these networks. For example, the Commission should not put USAC in the position of second-guessing the decisions of health care providers or requiring or permitting USAC to perform an independent analysis of whether building is appropriate in a given situation. This would be a recipe for uncertainty and smothering delays.

Instead, the process should be identical to the existing competitive bidding process: a request for proposals (that is agnostic on constructing or leasing); and the scoring of those proposals with price being weighted greater than any other single factor. No further showing should be needed. In the end, the issue is whether RHC funding is being expended in the most cost-effective way. The Commission has suggested no concerns that this did not take place in the Pilot Program. Therefore, with the minor modifications noted above, the current process should be left unchanged.

[21] *See RHC PN* at n.43 (noting reliability and quality as factors other than price).

III. CONCLUSION

In successfully deploying affordable broadband to health care providers in some of the most difficult areas to reach in the country, HIEM realized the promise of the Pilot Program. HIEM did so by being true to the Commission's commitment to competition as the best method to ensure cost effective use of limited universal service funding. The Commission must maintain this commitment by continuing to permit the construction of facilities where it is less costly to do so – HIEM's experience shows that failure to do so will waste limited universal service subsidies.

Respectfully submitted,

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